Name: ________________________________ **Date:**___________

How have you been feeling recently? Please check the appropriate column

Symptom	**0** Not at all	**1** Slight	**2** Mild	**3** Mild to Moderate	**4** Moderate	**5** Severe	**6** Extreme
Headache							
Nausea							
Vomiting							
Balance problems							
Dizziness							
Double vision/blurry vision							
Fatigue							
Sleep problems							
Sensitivity to light							
Sensitivity to noise							
Irritability							
Sadness							
Nervousness							
Feeling more emotional							
Feeling slowed down							
Feeling mentally foggy							
Difficulty concentrating							
Difficulty with memory							
Neck pain or stiffness							
Numbness/tingling							

Do you have a headache right now? Y/N How bad is it from 1-6? ______

Hours of sleep last night______ Last dose of pain medication____________________

Comments____

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